



Metro Nashville Employee Benefit Handbook For Eligible Charter School Employees



YOU SERVE METRO. WE SERVE YOU.

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Charter School Employees

Charter School employees are not employees of Metropolitan Nashville Government. However, eligible Charter School employees do have access to Metro Government insurance benefits which are paid for by each individual charter school and some benefits and premiums may vary from school to school (check with your school for specific benefits and premium amounts). Benefits for eligible Charter School employees are handled through the Metro Nashville Public Schools (MNPS) Benefit Office.

Introduction

Accessing your Benefits Information

Visit Human Resources on the web at www.nashville.gov to get answers regarding your benefit questions and to access insurance carriers, summary plan descriptions, online health and retirement tools as well as the latest news concerning your benefits.

This Document...

This document presents an overview of Metro benefits and is intended for informational purposes only. If there is a difference between this overview and the official plan documents or provider contracts, the official plan documents and provider contracts will govern. For more detailed information, please refer to Metro Human Resources' website or your insurance carrier's website.

HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care, or as outlined in the Metro Human Resources – Notice of Privacy Practice found on Human Resources' website at www.nashville.gov. If you have questions about your claims please contact your insurance carrier first. If, after contacting the carrier, you need Metro to assist you with any claim issues, you may be required to provide Metro with written authorization to release information related to your claim.

Disclosure of Grandfather Status under the Patient Protection and Affordable Care Act

Metro Nashville Government believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits. Annual lifetime limits continue to apply to custom built shoes and travel expenses for organ transplants. Metro Nashville Government has determined that these are not essential benefits for purposes of the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Metro Human Resources (615) 862-6640. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

IMPORTANT CONTACTS

PLAN	CARRIER	WEBSITE	PHONE
Medical	BlueCross BlueShield (BCBS) PPO	bcbst.com/members/metro-gov	(800) 367-7790
	Cigna Choice Fund	If enrolled: myCigna.com If not yet enrolled: mycignaplans.com (ID: metro2020; password: Cigna2020)	(800) 244-6224 (800) 401-4041
Dental	BlueCross BlueShield of TN	bcbst.com/members/metro-gov	(800) 367-7790
Vision	NVA	e-nva.com (user name: metro; password: vision1)	(800) 672-7723
Disability	The Standard	standard.com	(888) 494-9491
Life Insurance	Prudential	prudential.com/mybenefits	(877) 232-3619
Financial wellness	Prudential	prudential.com/metronashville	N/A
COBRA	COBRAGuard, an iTedium solution	cobraguard.net	(866) 442-6272
General	Metro Human Resources	nashville.gov/human-resources	(615) 862-6700

Benefits at a Glance

Eligible Charter school employees have the option to enroll in the following benefit plans based upon the benefits elected by their charter school. You may make changes to your benefits within 60 days of an eligible change in status or during Annual Enrollment.

Core Benefit Options and Highlights

Medical	Plan Options: <ul style="list-style-type: none">• BCBS PPO – 80/20% coinsurance plan with copays• CIGNA Choice Fund – HRA funded by Metro to pay first dollar claims before you pay a deductible
Dental	Plan Options – both share the same network of dentists: <ul style="list-style-type: none">• Flexible – \$1,000 annual benefit max with in- and out-of-network dentists• Limited – schedule of benefits with in-network dentists only
Basic Life AD&D Insurance	<ul style="list-style-type: none">• \$50,000 basic term life• \$50,000 Accidental Death & Dismemberment insurance

Optional Benefits and Highlights

Vision	Plan Options: <ul style="list-style-type: none">• Basic – eye exam every 12 months; glasses or contacts every 24 months• Enhanced – eye exam every 12 months; glasses or contacts every 12 months; 100% coverage for standard progressives and polycarbonates
Short-Term Disability	60% of weekly pay; benefit begins once disabled 7 days with maximum of 180 days
Long-Term Disability	50% of monthly pay; benefit begins once disabled 180 days
Supplemental Life	Guaranteed coverage for new hires up to \$200,000 with option to increase to \$500,000 with proof of good health during Annual Enrollment
Dependent Life	<ul style="list-style-type: none">• Must enroll in Supplemental life to purchase Dependent Life• \$10,000 to \$50,000 spouse/domestic partner coverage; \$5,000 each eligible dependent child

Enrollment & Eligibility

Eligible Employees and Coverage Effective Date

Eligible charter school employees who are regularly and consistently working 20 or more hours per week are eligible to enroll in benefits. Insurance and benefit coverage is effective the first of the month after you have worked 30 days.

Your coverage will end when your employment ends or when you change to a part-time status working less than 20 hours per week.

Opting Out of Coverage

Employees who can enroll in other medical and/or dental coverage may opt out of Metro's insurance coverage. To opt out, you must provide proof of other non-Medicare coverage – either an insurance card in the employee's name or a letter from the other insurance company. If you opt out and later lose your non-Metro medical or dental coverage or have an eligible change in status, you have 60 calendar days to re-enroll in Metro's medical or dental plan.

Coverage Levels

You may choose from two levels of medical, dental and vision coverage:

- Employee Only;
- Employee + Child(ren) – employee plus one or more dependent children (no spouse/domestic partner); or
- Employee + Family – employee, spouse/domestic partner plus one or more children.

Eligible Dependents

You may elect family coverage and enroll your eligible dependents in your medical, dental, vision and dependent life insurance (life insurance coverage up to age 24). Eligible dependents include your:

- Legally recognized spouse, while not divorced or legally separated;
- domestic partner (documentation will be required proving you've shared a primary residence for the last 365 days and you are financially interdependent upon one another); and
- dependent child(ren) from birth up to age 26 if he/she:
 - is your or your domestic partner's child by birth, legal adoption, legal guardianship or court order who may or may not reside in your home the majority of the time on an annual basis;
 - is your stepchild;
 - is a foster child living in your residence in accordance with a "Foster Care Placement" which means and is defined as the supervised adoption period prior to final adoption, as approved by a court of competent jurisdiction;
 - dependent child(ren) over age 26, if coverage under Metro benefits has been continuous and he/she is incapable of self-sustaining employment by reason of intellectual or physical disability (contact Human Resources for details).

The following are not eligible for Metro benefits:

- foster children (placed in the home for care, but not adoption);
- ex-spouses or ex-domestic partners, except as allowed under COBRA; or
- parents of the employee or spouse/domestic partner.

Eligible Changes in Status

The benefits you choose at your initial enrollment or during Annual Enrollment remain in effect for the entire plan year unless you have an eligible change in status such as:

- Marriage or divorce;
- Birth or adoption of a child;
- Change in job status for you or your dependent;
- Loss of coverage for you or your dependent; or
- Death of a covered eligible dependent.

You must notify Metro Nashville Public Schools (MNPS) and provide documentation within 60 calendar days of an eligible change in status to make a change in your benefit elections. Not notifying MNPS timely may prevent you from adding a dependent until the next Annual Enrollment or may require you to pay family premiums for the remainder of the plan year when a dependent is no longer eligible.

For a complete list of eligible changes in status and instructions on changing your benefit elections, contact your HR Representative or MNPS.

Metro Pensioners may not add dependents during Annual Enrollment and may only add dependents within 60 days of an eligible change in status.

Pre-Tax Payroll Deductions

Medical, dental and vision insurance premiums are deducted from your pay in pre-tax dollars, which lowers your taxable income (unless you are enrolling a domestic partner and/or his/her dependent children who are not your tax dependents, in which case premiums will be paid as after-tax). You may make an election during Annual Enrollment to have your premiums deducted in after-tax dollars. Call MNPS for more information.

COBRA Continuation Coverage

If you or your dependents lose your eligibility for health care coverage for certain reasons, you will be allowed to continue coverage for a certain period of time under COBRA provisions. Your dependents have the right to continue coverage even if you do not elect to continue your own coverage. Metro does not pay for coverage under COBRA; you or your dependent will pay 100% of the cost plus a 2% administration fee.

You or your dependents are eligible for COBRA continuation if coverage ends because:

- Your employment ends for reasons other than gross misconduct;
- Your work hours are reduced so that you no longer qualify for coverage;
- You die;

- You get divorced or legally separated; or
- Your dependent child becomes ineligible for coverage.

If you or your dependents qualify for COBRA, you will be mailed a packet with rate information and payment instructions from Metro's COBRA administrator.

Women's Health Provisions

No matter which medical plan option you choose, your hospital coverage for childbirth will be for the same minimum number of days, as required by federal law.

- If your baby is delivered vaginally, you may stay in the hospital at least 48 hours (two days) after the birth;
- If you have a cesarean section, you may stay in the hospital at least 96 hours (four days) after the birth; or
- If the attending physician believes you need a longer stay, you may receive benefits for additional days if your doctor obtains pre-authorization from the insurance company. On the other hand, if you and your doctor agree that, in your case, the minimum number of days is not necessary, you may be released from the hospital earlier.

Under the Women's Health and Cancer Rights Act of 1998, all health plans that provide mastectomy coverage are also required to provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance; and
- prostheses (artificial replacements) and physical complications at all stages of the mastectomy, including lymphodemas.

Coordination of Benefits

Regardless of which medical plan you elect, you must be sure to notify your insurance carrier if your dependents receive health coverage outside of Metro's plan (for example, through your spouse/domestic partner's insurance plan at work or by qualifying for Medicare).

If your dependent has coverage elsewhere, a process called coordination of benefits (COB) comes into play. COB simply means that benefits are coordinated between your dependent's coverage under your Metro plan and another plan. This process ensures that benefit payments are not duplicated and helps hold down the rising cost of health insurance.

Medicare Coverage

If you become eligible for Medicare while you are still actively employed by Metro, you are not required by Metro to take Medicare Parts A and B. However, once you are retired from Metro, you and your dependents are required to enroll in Medicare Parts A and B as soon as you first become eligible – regardless of other coverage you have or your employment status outside of Metro. If you do not enroll in Parts A and B, your medical claims will be

coordinated as if you did have Medicare.

Subrogation

If you or your dependent receives benefits under Metro's health plan as a result of an injury or illness caused by another person, Metro has the right to recover payment from that person and his/her insurer. This "subrogation right" applies to all payments made by Metro's plan for related medical services.

You or your dependent may be asked to provide information and otherwise help in the recovery process. If you fail to do so, or if you settle a claim without the written consent of Metro's plan administrator, you will be responsible for paying any attorneys' fees and court costs incurred in the recovery process.

Your Medical Plans

BlueCross BlueShield PPO

The BCBS PPO plan is an 80/20 coinsurance plan with copays that allow you the flexibility to select your physicians without referrals. After the annual out-of-pocket maximum has been met, you will continue to pay your copay, but your coinsurance level will be 100%. To receive the maximum benefits, you should use an in-network provider that participates in Network P. You may contact BCBS or visit their website for a list of in-network providers. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level (60/40)

and you may be required to pay the entire bill up front and file a claim with BCBS for reimbursement.

Preventive Care

This plan provides each participant 100% preventive care coverage up to \$750 of in-network claims, then coverage is at 80% in-network. This means that your annual physical will be covered at 100% up to \$750 for each member covered under your plan with any expenses above \$750 covered at 80% as long as you use an in-network provider.

Please note that wellness screenings, such as the annual well-woman visit, mammogram, men's PSA screening, and colonoscopy, will continue to be covered in-network at 80% and are not considered a part of the annual preventive benefit.

Pharmacy Benefits

Prescription drug coverage is provided by BCBS and is available through most retail and home delivery pharmacies. You may obtain a 34-day supply for the cost of one copay and a 35- to 102-day supply for the cost of two copays which may be filled at certain retail pharmacies or through home delivery and mail order programs. The generic drug copay is considerably less than the copay of a brand name drug.

If you take a maintenance prescription on a regular basis, you should talk with your doctor about writing your prescription so that you may take advantage of the two copays rather than three. A list of all participating pharmacies may be obtained by calling BCBS or by

visiting their website.

CIGNA Choice Fund

Fund and Deductible

The CIGNA Choice Fund is a health reimbursement arrangement where traditional medical coverage is combined with a Fund of contributions made by Metro. The HRA Fund can be used to pay for eligible health care and pharmacy expenses during the plan year. CIGNA has negotiated discounts with providers in their Open Access Plus Network and to receive the maximum benefits you should select providers in this network. There are no copays with the CIGNA Choice Fund; the full cost of the negotiated discount is the amount that is owed to the provider. If you choose to use an out-of-network provider, you will still receive benefits, but at a lower level and you may be required to pay the entire bill up front and file a claim with CIGNA for reimbursement.

Any money you have remaining in your HRA Fund at the end of the plan year will roll over to the next plan year and lower the amount of your deductible for that year.

Once the Fund has been exhausted, there is a deductible that you must meet before the plan begins paying at the coinsurance level. When your annual out-of-pocket maximum has been met, you have 100% coverage for the remainder of the plan year.

If you become enrolled with a coverage effective date of April 1 or later, your HRA Fund and deductible

will be prorated based upon the quarter in which your coverage becomes effective. If during the same year that your coverage becomes effective, you add a dependent as a result of an eligible change in status, the HRA Fund and deductible will be increased as if you had family coverage on your insurance effective date. If you change from family coverage to single coverage at any point during the year, the HRA Fund and deductible will not be decreased or prorated.

Incentive Programs

Charter school employees and their spouses/domestic partners may earn incentive dollars that will be added to your Fund and thereby decrease your deductible by qualifying and participating in one of the incentive programs offered by CIGNA. These programs and incentives are available on an annual basis:

- Health Risk Assessment – this online questionnaire is short, confidential and provides you with a personalized health profile to help you take steps toward better health.
 - \$100 per person upon completion (\$200 maximum per family).
- Chronic Health Condition Support Program – personalized support from Cigna health coaches for chronic conditions including COPD, asthma, depression, low back pain, osteoarthritis and weight complications.
 - \$100 per person (\$200 maximum per family; each

person is only eligible to receive one incentive per year).

- Lifestyle Management Program – personalized support from CIGNA health coaches for lifestyle behaviors such as tobacco cessation, stress and weight loss.
 - \$50 per person (\$200 maximum per family, \$100 maximum per person).
- Healthy Pregnancies, Healthy BabiesSM – Participation in the program is designed to help you and your baby stay healthy during your pregnancy. This program encourages you to get prenatal care early in your pregnancy. When you complete the program and after your baby is born, you will receive the incentive dollars.
 - \$150 if you enroll by the end of your first trimester, or
 - \$75 if you enroll by the end of your second trimester.

Preventive Care

In-network preventative care services are covered at 100% and are not applied against the HRA Fund. Preventive services received from an out-of-network provider are covered at 70% and do reduce the dollars in your Fund.

Pharmacy Benefits

Prescription drug coverage is provided by CIGNA and is available through most pharmacies and by mail order. While you are in the Fund and deductible levels, you will pay the full price of the discounted cost of the generic or brand-name drug. Once you have moved into the coinsurance level, you will pay 10% of the

discounted cost for generic drugs and 30% of the discounted cost for brand name drugs.

The pharmacy will determine the amount you owe, if any, for the prescription drug depending upon the fund balance in your HRA Fund and if you have met your deductible. If you have exhausted your fund but not yet met the deductible, you will pay the full price of the discounted cost of the drug at the time you pick up the drug.

A list of all participating pharmacies may be obtained by calling CIGNA or by visiting their website.

Your Dental Plans

Metro offers two dental plan options – either the Flexible or Limited plan and both are provided by BlueCross BlueShield. While both dental plans share the same DentalBlue network of dentists, each plan's benefit payment structure is different (see the Dental Plan Comparison Highlights).

The Flexible Plan gives you the flexibility to go both in-network and out-of-network for care and pays a percentage of the charges. The Limited Plan only pays for in-network care and has a flat dollar copay for most services.

2020 MEDICAL

MEDICAL BENEFITS ... AT A GLANCE

	BCBS PPO		CIGNA CHOICE FUND	
	In-Network BLUE NETWORK P	Out-of-Network ¹	In-Network OPEN ACCESS PLUS NETWORK	Out-of-Network ¹
Health Reimbursement Account Fund (Metro funded) ^{2,3}	N/A	N/A	\$1,100/employee only \$2,200/family	
Your Share of the Deductible ³	\$0	\$200/employee only \$600/family	\$450/employee only \$900/family	
Coinsurance Maximum ³	\$1,000/employee only \$2,000/family	\$5,000/employee only \$10,000/family	\$700/employee only \$1,400/family	\$4,550/employee only \$9,100/family
Annual Out-of-Pocket Maximum ³ (includes deduct. & coins. but not copays)	\$1,000/employee only \$2,000/family	\$5,000/employee only \$10,000/family	\$1,150/employee only \$2,300/family	\$5,000/employee only \$10,000/family

Medical Services

After deductible, plan pays... (unless otherwise noted)

Well Care/Preventive Care

- Age 7 and older	100% up to \$750, then 80% ⁴	60%	100%	70%
- Under age 7	80%	60%	100%	70%

Office Visits

- Primary Care Physician ⁵	80% after \$20 copay	60% after \$20 copay	90%	70%
- Specialist	80% after \$30 copay	60% after \$30 copay	90%	70%

In-office Procedures (surgery, consultation, allergy injections)	80% after office visit copay	60% after office visit copay	90%	70%
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Maternity

- Prenatal Care	You pay \$20 copay for initial visit	You pay \$20 copay for initial visit	90%	70%
- Delivery	80%	60%	90%	70%
Hospital	80%	60%	90%	70%

Emergency Room	80% after \$100 copay (copay waived if admitted)	60% after \$100 copay (copay waived if admitted)	90%	90%
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Mental Health/Substance Abuse

- Outpatient	80% after \$20 copay	60% after \$20 copay	90%	70%
- Inpatient (pre-authorization required)	80%	60%	90%	70%

Prescription Drugs

You pay...

1-month supply		After deductible:
- Generic	\$10 copay	10% of discounted cost
- Brand	\$30 copay	30% of discounted cost
3-month supply (maintenance drugs)	2 times above copays through certain retail pharmacies and mail order; see page 3	Same as above through certain retail pharmacies and mail order; see page 3

¹ If you use an out-of-network provider and charges exceed the Maximum Allowable Charge (MAC), you will be responsible for the difference. In-network providers have agreed not to exceed MAC.

² Pensioners with Medicare A & B are not eligible to receive the Health Reimbursement Account Fund.

³ If you enroll in the employee + child(ren) coverage tier, Metro's HRA Fund contribution (Cigna Choice Fund), your share of the deductible, coinsurance maximum and annual out-of-pocket maximum is the same as the employee + family coverage tier.

⁴ Screening colonoscopies, mammograms, PSA tests and PAP exams are covered at 80% after office visit copay (in-network) and 60% after office visit copay (out-of-network), but are not included in the \$750 well-care benefit limit.

⁵ Primary Care Physicians include pediatricians, family and general practitioners, internists and OB/GYNs. Specialists include physicians highly trained in specific areas such as cardiology, dermatology, neurology, podiatry, oncology and specialized OB/GYNs.

See Summary of Benefits and Coverage (SBC) for more information.

2020 DENTAL

DENTAL BENEFITS ... AT A GLANCE

	FLEXIBLE PLAN	LIMITED PLAN
	In-Network ¹ (out-of-network coverage available)	In-Network Only ¹ (no out-of-network coverage)
Annual Deductible	\$75/person \$225/family	\$0
Plan pays...		See schedule of benefits for cost by service²
Preventive/Diagnostic (2 exams/cleanings every 12 months, x-rays, sealants, fluoride)	100%; no deductible	100% for most services
Basic Restorative (fillings, extractions, oral surgery, root canals, periodontics)	80%; no deductible	100% for some services; you pay flat fee for other services
Major Restorative (crowns, bridges, dentures, implants)	50% after deductible	You pay flat fee for most services; implants not covered
Orthodontia (child and adult)	50% after annual deductible and one-time \$100 orthodontia deductible	You pay flat fee for most services
Lifetime Orthodontia Maximum	\$1,000/person	See schedule of benefits ²
TMJ (temporomandibular joint) Treatment	50% after annual deductible and \$100 annual TMJ deductible	Not covered
Lifetime TMJ Maximum	\$750/person	N/A
Annual Benefit Maximum	\$1,000/person (excludes orthodontia, TMJ)	N/A

¹ If there is no network provider within a 30-mile radius of your home, you may use an out-of-network provider and receive in-network benefits. Contact BCBS for instructions.

² View the Limited Plan schedule of benefits at bcbst.com/members/metro-gov.

VISION

Vision coverage, offered through National Vision Administrators (NVA), covers eye exams, frames, lenses and contacts. You have two choices for vision coverage: the Basic Plan or the Enhanced Plan.

HOW THE VISION PLANS WORK

You receive the highest benefits when you use NVA's network of providers. The network includes many independent optometrists, ophthalmologists and opticians, as well as national retail optical providers, such as Walmart and Visionworks. For a list of network providers, visit e-nva.com (user name: metro; password: vision1). You are responsible for any costs over the reimbursed or allowed amount shown in the chart below.

VISION BENEFITS ... AT A GLANCE

	BASIC PLAN		ENHANCED PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$0		\$0	
Exams	You pay \$10 copay	Plan pays up to \$45	You pay \$10 copay	Plan pays up to \$45
Lenses	You pay:	Plan pays:	You pay:	Plan pays:
- Single Vision	\$10 copay	Up to \$40	\$25 copay	Up to \$40
- Bifocals	\$10 copay	Up to \$60	\$25 copay	Up to \$60
- Trifocal	\$10 copay	Up to \$80	\$25 copay	Up to \$80
- Lenticular	\$10 copay	Up to \$80	\$25 copay	Up to \$80
Lens Options	Plan pays:		Plan pays:	
- Scratch-resistant Coating	100%	Not covered	100%	Not covered
- Standard Progressives	Not covered	Not covered	100%	Not covered
- Polycarbonate	Not covered	Not covered	100%	Not covered
Frames	Plan pays up to \$130 ¹	Plan pays up to \$50	Plan pays up to \$150 ¹	Plan pays up to \$50
Contacts (in lieu of frames/lenses)				
- Elective	Plan pays up to \$125 after \$10 copay ¹	Plan pays up to \$125	Plan pays up to \$140 ¹	Plan pays up to \$140
- Medically Necessary	Plan pays 100%	Plan pays up to \$210	Plan pays 100%	Plan pays up to \$210
Covers...	One exam every 12 months; lenses, frames and contacts every 24 months		Exams, lenses, frames and contacts every 12 months	

¹ In many cases, NVA offers a discount on amounts exceeding retail allowance; ask your network provider.

Life Insurance

Basic Life and AD&D Insurance

Metro provides employees of eligible charter schools – at no cost to you – with basic life insurance and accidental death and dismemberment (AD&D) insurance. Each eligible employee is covered with \$50,000 in basic life and \$50,000 for AD&D. Eligible employees over the age of 65 are covered in the amount of \$32,500 for both basic life and AD&D. If you are eligible as a service pensioner, Metro will provide you with \$10,000 in basic life insurance coverage.

Accidental death and dismemberment insurance provides you or your beneficiary with a benefit if you suffer certain accidental injuries or if you die from an accident. The amount of AD&D injury benefit is based on the type of injury while the amount of the AD&D death benefit is based on the amount of your coverage at the time of your death.

Please refer to the life insurance policy located on Metro Human Resources' website for more information concerning your life insurance benefits.

Supplemental Life

As a new employee, you may elect to purchase additional life insurance in \$10,000 increments up to a maximum of \$200,000 without proof of good health. If you have a known condition that might preclude you from being approved by the insurance company, you should strongly consider enrolling when you first become eligible. If you decide to

wait and enroll later, you will be required to provide proof of good health.

If you are already an employee or enrolled in supplemental life, you may increase your coverage in increments of \$10,000 to a maximum of \$500,000 with proof of good health (or evidence of insurability – EOI) at Annual Enrollment or if you have certain eligible changes in status. If you are already enrolled, you may increase your coverage by \$10,000 at Annual Enrollment without proof of good health (as long as the increase does not take you above \$200,000).

Dependent Life

If you are enrolled in supplemental life insurance, you may also enroll in dependent life which provides up to \$50,000 in coverage on your spouse/domestic partner and \$5,000 for each dependent child (up to age 24) regardless of the number of dependents. The employee is automatically the beneficiary for dependent life claims.

You may enroll your spouse/domestic partner with \$10,000 or \$20,000 in coverage without proof of good health (EOI) if you enroll when you first become eligible – either at benefit eligibility or when they first become your eligible dependent. Dependent children are not subject to proof of good health. During Annual Enrollment or at the time of an eligible change in status, you'll have an opportunity to increase coverage up to \$50,000 subject to EOI.

Accelerated Death Benefit

If as an eligible employee you become terminally ill and are not expected to live more than twelve months, you may request 80% of your life insurance benefits not to exceed \$500,000 (for both basic and supplemental life) payable to you in one lump sum or equal monthly installments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary.

Waiver of Premium

If you are under the age of 60 and you become totally disabled according to the life insurance carrier's standards (not Metro's), you may apply for the waiver of premium for basic life, supplemental life and dependent life benefits and have your premiums waived as long as you continue to be disabled. You must apply within 12 months of the date you became disabled. If approved, your pre-retirement level of benefits may remain in effect until your age 70 as long as you continue to meet the life insurance carrier's criteria.

If you qualify for the waiver of premium, this is a free benefit to you. If you are denied for the waiver of premium benefit, you have 30 days from the date of the denial to appeal

the insurance company's decision. If your appeal is denied, or you elect not to appeal the denial, you may convert to an individual policy; however, you must make written application and payment of premium within 31 days from the time the insurance company denies your waiver of premium application. To appeal or convert, you must contact the life insurance company directly.

Beneficiary

You may change your beneficiary at any time by completing a new form with MNPS. When you experience an eligible change in status (such as with a marriage, divorce or death) you should consider updating your beneficiary at that time. You may also name different beneficiaries to receive your basic life and supplemental life benefits.

Conversion & Portability Rights

If you leave your job, your life insurance coverage will end. To convert and/or port all or part of your life insurance benefits to an individual policy, you must apply and pay for the first premium within 31 days after your coverage ends. For more information about your conversion and portability rights, contact the life insurance carrier.

Short-Term Disability

Short-Term Disability (STD) is an optional benefit and replaces a portion of your Metro pay for up to 180 days if you become disabled by an injury, illness, or medical condition – including pregnancy and mental illness – cannot work and suffer a loss of income. After a seven day waiting period, benefits are payable at 60% of your weekly earnings up to a maximum weekly benefit of \$1,250.

If you do not have 10 years of credited service with Metro, you should consider enrolling in this benefit to protect your income and preserve any sick days you might have.

Late Enrollment Penalty

If you do not enroll in this benefit within 60 days of becoming eligible, you will be subject to the following late enrollment penalty. If you file a claim for anything other than an accidental injury during the first 12 months after your coverage takes effect, your benefits will become payable after you have been continuously disabled for 60 consecutive days and remain disabled.

Your Benefit

STD benefits are payable for up to

180 consecutive days from the date of your disability begins. Actual payments will begin at the end of a seven day waiting period. During this waiting period, you may use sick or vacation leave. The STD benefits you receive are not taxable but are coordinated with other Metro benefits you may receive. While you receive STD benefits, you will be eligible to continue to your medical and dental insurance and must make an election as to how to pay your premiums during this time.

If you are also eligible for Family Medical Leave (FMLA), your STD and FMLA time will run concurrently with each other. If pregnancy and childbirth is your disabling condition, please keep in mind that you will only receive STD benefits for the period of time your doctor and the insurance carrier deem you disabled – typically six weeks after a normal delivery.

Applying for STD Benefits

To apply for STD benefits, you should contact your HR Representative who will assist you in completing an application. You will also be required to provide medical documentation to support your claim. The insurance company will notify you when and if you are approved.

Long-Term Disability

Long-Term Disability (LTD) is an optional benefit and replaces a portion of your Metro pay if you become disabled by an injury, illness, or medical condition and cannot work. After a 180-day waiting period (typically after short-term disability benefits end), benefits are payable at 50% of your monthly earnings up to a maximum monthly benefit of \$7,500.

You are not required to enroll in short-term disability (STD) to enroll in LTD benefits – you may enroll in one or the other or both. If you do not have 10 years of credited service with Metro, you should consider enrolling in this benefit.

Proof of Good Health

If you do not enroll in LTD benefits within 60 days of becoming eligible, proof of your good health (evidence of insurability – EOI) will be required to enroll.

Pre-existing Condition

If you have a pre-existing condition in the 90 days before you enroll in LTD insurance, you may not be eligible for benefits for that condition for 12 months after the effective date of your coverage. After 12 months of continuous coverage, the pre-existing condition is waived.

Your Benefit

LTD benefits are payable monthly after you have been disabled for 180 consecutive days. During this waiting period, you may use sick or vacation leave in addition to any STD or FMLA

for which you may be eligible. The LTD benefits you receive are not taxable but are coordinated with other benefits you may receive. If you become disabled before age 62, benefits may continue during disability until your age 65. If you become disabled after age 62 or older, the length of your payments vary upon when your disability begins. Contact the insurance carrier for more information.

Once you begin receiving LTD benefits, you will no longer be a Metro employee and will need to resign from employment. You will be eligible to continue to your medical, dental and vision insurance through COBRA if you elected these benefits as an active employee. Any vacation pay you receive at the end of your employment will not affect your LTD benefits.

If you die while receiving LTD benefits, your eligible survivor may be entitled to a benefit based on your earnings while working.

Applying for LTD Benefits

To apply for LTD benefits, you should contact your HR Representative who will assist you in completing an application. You will also be required to provide medical documentation to support your claim. If you are transitioning from STD to LTD, you will not be required to file a new claim form. The insurance company will notify you when and if you are approved.

What Happens to Your Benefits...

If you are on Family Medical Leave (FMLA) or Short-Term Disability (STD)?

While you are on FMLA and/or STD, your medical, dental, basic life insurance and any optional benefits you are enrolled in will continue. As long as you are in a paid status using (using sick or vacation leave) premiums will continue to be withheld from your paycheck.

If all or part of your FMLA or STD will be unpaid (and you're not being paid for sick or vacation leave), you must make an election as to how you will pay your premiums while you are on leave. Your options are to:

- Pre-pay your premiums before taking leave;
- Pay premiums on a monthly basis direct to Metro on an after-tax basis; or
- Hold your premiums in arrears until you return to work and then have premiums withheld from your paychecks over the same number of pay periods as the missed premiums would have been withheld.
- You may also cancel your participation in long-term disability, supplemental life or dependent life while you are on FMLA. If you reenroll in these benefits within 31 days of returning from leave, you will not be required to provide Evidence of Insurability.

If you do not return to work at the end of your FMLA or STD leave, your coverage will terminate on the actual

paycheck issue date of your second missed premium and you will be offered COBRA.

If you take Leave Without Pay?

If you take a leave without pay (unpaid leave of absence), your coverage will terminate on the actual paycheck issue date of your second missed premium and you will be offered COBRA.

If your leave is less than 30 days, your coverage will be reinstated when you return to work. If your leave is more than 30 days, your coverage will be reinstated effective the first of the month following 30 days from the date you returned from leave.

Evidence of Insurability for supplemental life, dependent life and LTD will be required when you return from leave.

If you go on Military Leave?

You must make an election to either discontinue or continue your medical and dental coverage for a maximum of 24 months while on active military duty (COBRA will not be offered at the end of the 24-month period). If you later decide to drop your coverage, you must notify MNPS in writing. Medical and dental premiums will be deducted from your regular earnings or any partial pay you receive. Your basic life insurance will continue to be paid by Metro while you are on active duty.

If you are enrolled in vision, supplemental life or dependent life, you may keep these benefits while

you are on military leave or you may elect to cancel these benefits and reenroll when you return from leave. If you choose to cancel your supplemental life and/or dependent life while you are on leave, you will have 31 days from the date you return to work to reenroll without providing Evidence of Insurability. Premiums for these benefits will NOT be deducted from any partial pay you receive so you must make an election below as to how you wish to pay these premiums. Your options are to:

- Pre-pay your premiums before taking leave;
- Pay premiums on a monthly basis direct to Metro on an after-tax basis; or
- Hold your premiums in arrears until you return to work and then have premiums withheld from your paychecks over the same number of pay periods as the missed premiums would have been withheld.
- You may also cancel your participation in vision, supplemental life or dependent life while you are on leave. If you reenroll in these benefits within 31 days of returning from leave, you will not be required to provide Evidence of Insurability.

While on military leave, you are not eligible to maintain your short-term or long-term disability coverage. If you return to work within 90 days, your coverage is automatically reinstated. If you return to work after 90 days, you will be treated as a new employee without a late enrollment penalty.

If your employment ends?

Your benefits coverage will terminate at the end of the month of your last day on payroll, but premiums will continue to be deducted through your last paycheck.

If your employment ends with Metro for any reason other than gross misconduct, you will be offered COBRA and Metro's COBRA administrator will contact you by mail with information and premium rates.

If you were enrolled in medical insurance, you will receive a Certificate of Creditable Coverage from your insurance company within 14 days from the date your insurance coverage ends. This letter may be given to your next employer to show that you had prior insurance coverage.

As a member of the benefit system, you were enrolled in a Basic Term Life Group Insurance policy and you may have several options available to you and your eligible dependents to continue all or part of your current life insurance benefits. You must elect this coverage and make premium payment to the insurance carrier within 31 days of your employment end date. If your employment is ending due to your disability, you may be eligible for the Waiver of Premium life insurance benefit. If enrolled, your Supplemental Life Insurance policy is portable at group insurance rates (you must apply and make payment within 31 days of your employment end date). To continue your basic term life and/or supplemental life policy contact the insurance carrier immediately.

If you have vested and are eligible, you may be entitled to receive a future retirement benefit. You may be eligible for this benefit as early as age 60 and no later than age 65 depending upon your total credited service with Metro. If eligible, it is your responsibility to contact Metro Human Resources in advance of your

retirement age to begin this process. If you die before your retirement benefits begin, your legal spouse, domestic partner (who has a Declaration of Domestic Partnership already on file with Metro Human Resources) or minor dependent child(ren) may be entitled to receive pension benefits immediately.

Pension Benefits – Eligible Charter School Employees

Service Retirement Pension

For eligible Charter School employees, Metro offers – at no cost to you – a monthly service retirement benefit. If you are vested and die, survivor benefits will be payable to your legal spouse, domestic partner (who has a Declaration of Domestic Partnership already on file with Metro Human Resources) or eligible dependent child(ren), if applicable.

There are two types of retirement

pensions – a normal service pension or an early reduced pension benefit. If you elect an early service pension, you will receive a 4% reduction per year for each of the first five years you retire early and an 8% reduction for each year over five years.

You may estimate your retirement benefit using the online pension estimator on Metro Human Resources' website.

Vesting

- 10-year vesting for employees hired (and non-vested employees rehired) on/after January 1, 2013
- 5-year vesting for employees employed on or between October 1, 2001 and December 31, 2012 who vested before leaving employment

General Government Pension Plan

Normal Retirement

Benefits begin at age 60 once your age plus your years of service equal 85 points or at age 65 and 5 years

Early Retirement

Reduced benefits begin at age 50 once you have 10 years of service

Applying for Pension Benefits

You must apply for retirement benefits with Metro Human Resources and provide certain documents such as birth certificates, Social Security cards, marriage license or divorce decree at the time of your application. Contact Metro Human Resources to apply.

* The pension benefits discussed in this document pertain to the Metro – Division B pension plan which covers employees hired July 1995 and later and employees who made an election to transfer to Division B.

Insurance at Retirement

For information concerning eligibility for insurance benefits at retirement, please contact Metro Human Resources.



YOU SERVE METRO. WE SERVE YOU.



REQUIRED NOTICE

New Health Insurance Marketplace Coverage Options

As part of Health Care Reform, Metro Government is required to provide this notice to all Metro employees regardless of whether you are enrolled in Metro's health insurance benefits. Please note that while you are receiving this notice, you may not be eligible for insurance through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium or receive a tax credit if your employer does not offer coverage or the cost of coverage for just yourself through your employer is more than 9.5% of your household income for the year. The savings on your premium that you're eligible for depends on your household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Need More Information?

You may review Metro's health plans online at www.nashville.gov/Human-Resources.aspx or contact Metro Human Resources at 615-862-6700.

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